



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AHMED KHALIFA MD
1415 WHY 6, SUITE 400-D
SUGARLAND TX 77478

Respondent Name

TPCIGA FOR PAULA INSURANCE CO

Carrier's Austin Representative Box

Box Number 50

MFDR Tracking Number

M4-12-3433-01

MFDR Date Received

JULY 24, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am in receipt of the attached E.O.B. related to the date of service May 15, 2012. Based on this E.O.B. the medical bill of \$48.43 for the procedural code 77006-26 was denied. The rationale for the denial was 'This procedure combination is not compensable with another procedure.' Firstly, this procedure was pre-authorized and your denial of a pre-authorized procedure is in violation of DWC rule 134.600(c)(1). Secondly, this procedure, fluoroscopy, in no way could possibly be considered as a part of other procedures which are cervical injection."

Amount in Dispute: \$48.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TPCIGA supports the position statement provided by our medical review vendor Review Med, please see attached."

Review Med Position Summary: "We have reviewed the submitted request. Based on the National Correct Coding Initiatives Edits and the submitted billing, 7703-26 does not warrant reimbursement. This procedure is not separately reimbursable when billed with procedure 64490, unless billed with an appropriate modifier and documentation to support the modifier. The 77003-26 procedure was not billed with a modifier/documentation to override the NCCI edit."

Response Submitted by: TPCIGA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2012	CPT Code 77003-26	\$48.43	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits
 - Modifier 26 represents the professional component of services performed.
 - CCI Comprehensive/Component procedure.
 - 236-This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative.
 - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is CPT code 77003-26 bundled to another service/procedure performed on this date? Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b)(1), states "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

CPT code 77003-26 is defined as "Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid)."

According to the explanation of benefits, the respondent denied reimbursement for CPT code 77003-26 based upon reason code "236."

On the disputed date of service, the requestor billed CPT code 64490-50, 64491-50 and 77003-26.

The National Correct Coding Initiatives Policy Manual states "Radiological supervision and interpretation codes include all radiological services necessary to complete the service. CPT codes for fluoroscopy/fluoroscopic guidance (e.g., 76000, 76001, 77002, 77003) or ultrasound/ultrasound guidance (e.g., 76942, 76998) should not be reported separately."

Furthermore, the National Correct Coding Initiatives Edits finds that CPT code 77003 is a component of CPT code 64490 and 64491, a modifier is allowed to differentiate the service. The requestor utilized modifier 26 that designates that the billing is for the professional component of code 77003. Modifier 26 does not override the bundled policy. As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	06/12/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.